DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

Guidance for Applicants (GFA) No. TI 03 -005
Part I - Programmatic Guidance

Grants to Develop, Deliver, Document, and Evaluate Peer-Driven Recovery Support Services

Short Title: Recovery Community Services Program (RCSP II) Appendices

Application Due Date:
September 10, 2002

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*This program is being announced prior to the full annual appropriation for fiscal year (FY) 2003 for the Substance Abuse and Mental Health Services Administration's (SAMHSA) programs. Applications are invited based on the assumption that sufficient funds will be appropriated for FY 2003 to permit funding of a reasonable number of applications being hereby solicited. All applicants are reminded, however, that we cannot guarantee sufficient funds will be appropriated to permit

SAMHSA to fund any applications. Questions regarding the status of the appropriation of funds should be directed to the Grants Management Officer listed under “How to Get Help” in this announcement.

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[Note to Applicants: In addition to this Part I Programmatic Guidance, you need two additional documents to complete your application:

- **PART II - "General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements"**
- **Public Health Service Grant Application FORM 5161-1; See "Application Kit" section for instructions on obtaining these two documents.]**
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Appendix A:
Examples of Recovery Community Peer Support Services[1]

Recovery Support Meetings/Groups

- Peer-facilitated support groups
- Specialized support groups: homelessness, HIV, dual diagnosis, PTSD, culturally-specific
- Family support groups
- Recovery support/self-help groups
- Talking circles
- Recovery workshops
- Recovery coaching/mentoring

Peer Case Management and Case Advocacy

- Entitlement advocacy with government agencies for public assistance, SSI/SSD and other benefits
- Peer assistance with housing, advocacy with public housing placements
- Crisis assistance and peer interventions
- Legal clinics or referral to legal services

Life Skills

- Classes on money management, savings, and budgeting
- Peer counseling and/or peer support for issues of daily living (money, meals, medication, living skills)
- Classes in nutrition, meal planning, food buying, cooking
- Workshops on renting an apartment, buying a house, setting up utilities, etc.
- Workshops on parenting in recovery
- Workshops for families in recovery
- Workshops for recovering individuals to deal with families of origin
- Parenting groups
- Social skill workshops and groups

Health and Wellness

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[1] A preliminary version of this list was developed for a meeting, entitled "Working Through A Paradigm Shift," held for the 2001 cohort of Recovery Community Support Program grantees, May 2-3, 2002.

- Classes in HIV and STD prevention
- HIV management workshops
- Psychoeducational workshops (e.g., understanding depression, body image, maintaining intimate relationships)
- Wellness workshop series (e.g., stress management, meditation, yoga, acupuncture, massage)
- Health workshop series
- Sexuality workshop series
- Addiction workshop series
- Relapse prevention workshops
- Guest speaker/lecturer series
- Smoking cessation workshops
- Classes in cooking and nutrition
- Anger management training
- Bereavement support groups

Gender-Specific

- Men's and women's support groups
- Pre-employment assessment and services for men and women entering/returning to the workforce
- Reproductive health workshops
- Parenting skills workshops

Education and Career Planning

- English as a Second Language classes
- GED classes
- Reading and study skills program
- Counseling regarding college and career choices for adults
- Job skills and career aptitude workshops
- Vocational training
- Work readiness assessments
- Assistance with scholarships and financial aid
- Assistance with college applications
- Preparation for SAT and other college entrance tests
- Peer counseling for job readiness, job training, interviewing skills, appropriate attire, wardrobe maintenance and other employment behaviors and skills
- Job coaching
- Resume writing workshops

Leadership Skills Development

- Peer-leadership development workshops
- Skills development for board and committee representation
- Peer support group training and facilitation (how to conduct meetings)
- Peer counseling skills training and development
- Communication skills
- Conflict resolution skills
- Peer volunteer skill training: public health issues (HIV, TB, etc.), peer counseling, benefits advocacy, community resources, substance abuse, civic involvement, performing intakes, chairing meetings, defusing potentially violent situations.
- Citizenship classes
- Representation on advisory boards and policy committees
- Community service programs
- Diversity training
- Reading and study circles
- Consciousness-raising groups

Community Assessment and Education

- Community meetings and forums (to identify recovery community needs)
- Focus groups
- Surveys
- Information dissemination (about recovery, health, and related topics)
- Newsletter
- Speakers bureau (on recovery topics)
- Outreach activities

Physical Education and Fitness

- Weight lifting
- Aerobics
- Yoga
- Dance classes

Cultural Affairs

- Art classes
- Photography
- Music classes
- Art exhibits
- Performances
- Chorus

- Theater group
- Improvisational theater group
- Writing and journal workshops
- Videography workshops

Computer Skills

- Computer classes
- Computer labs
- Website development

Alcohol- and Drug-Free Social/Recreational Activities

- Movie nights
- Game nights
- Dances
- Potluck suppers and picnics
- Talent shows
- Holiday parties
- Pool and ping pong tournaments
- Field trips
- Basketball and softball leagues
- Snack bar/food service
- Sober bike runs

Other Services

- Library, resource center, clearinghouse
- Information and referral
- Hotline/Warmline
- Mentoring services
- Transportation assistance service
- Shower facilities for homeless
- Food bank
- Respite programs
- Copy shop services
- Thrift store
- Clubhouse orientations
- Study circles

Appendix B:
Models and References[2] on Peer Support Services

Models and References

As RCSP grantees begin to transition to a paradigm that emphasizes peer-driven recovery support services, they will find no shortage of examples. No model represents a template that can simply be copied without consideration of such basic questions as the culture, needs, and desires of the recovery community that the grantee is working in, or the resources, human as well as financial, that the grantee has available. Moreover, many of these models have significant weaknesses as well as strengths. However, collectively they are a tribute to the resourcefulness of communities that, working within a paradigm of self-help, find dignity, a sense of inter-connectedness and belonging, and, often, accomplishment and satisfaction. Viewed both separately and collectively, they can expand our horizons and vision.

The models that follow are only the tip of the iceberg. We start with models from the recovery community itself, and then move on to focus on a few models from other communities. We stress that we are discussing only on a few. The roots of self-help, mutual aid, and community organizing for collective good spread wide and deep. Some of these resources and models may apply to your program more than others. You many want to extract elements from some and leave the rest. However you may ultimately use these resources, they are offered as suggestions and sources of possible inspiration as you develop your RSCP peer-driven services.

Embedded in the discussion that follows are links to on-line resources where you can start learning more about these models. At the end of the Appendix is a brief annotated bibliography of selected print references, including academic articles. The RCSP TA Team has a copy of most of these articles and would be glad to share.

MODELS WITHIN THE RECOVERY COMMUNITY

RCSP Grantees

Prior to the shift in emphasis toward recovery support services, many RCSP grantees – past and present -- have identified and addressed support needs in their communities. Some of the highlights of these project activities include:

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[2] This document was prepared for a meeting of the RCSP Project Directors, entitled "Working Through a Paradigm Shift," that was held May 2-3, 2002.

- **Dual Diagnosis Anonymous** has adapted the 12-Step model to provide social and spiritual support for its members, who often felt excluded from traditional 12-step groups. In particular, many felt that their local groups did not understand the challenge of maintaining recovery while simultaneously complying with medication regimes. In addition to support meetings, Dual Diagnosis Anonymous has an interactive website, a hotline and has written its own Dual Diagnosis "Big Book", including a version targeted to youth with co-occurring disorders. www.dualdiagnosisanonymousworldservicesinc.com

- **PWRD (People With Recovery and Disabilities)** found that many of its members, facing multiple physical, cognitive and mental health challenges in addition to the challenge of sustaining recovery, wanted support and assistance in coordinating and juggling these various demands. PWRD has incorporated peer-driven elements of case management into its program. www.pimaprevention.org

- **Easy Does It** is poised to expand the classic recovery clubhouse model (see below) by developing and offering a broader array of recovery support services to their community. www.easydoesitinc.org

- **The Winners Circle** has addressed the needs of recovering ex-offenders by facilitating a series of ongoing peer-driven support groups, offering both adult and youth mentoring services and setting up a recovery resource library. www.tacs-il.org

- **Circles of Recovery II** works through trained Firestarters – individuals in recovery – to initiate Native American community change focused on healing and wellness. To support this "wellbriety" movement, they have developed talking circles, the "Indian Big Book" and other tools to promote wellness in Native communities. www.whitebison.org

- **PRO-A**, through its **PRO-ACT** chapter, has developed training and a curriculum so that family members can help other family members better understand addiction, treatment and recovery and help their loved ones find appropriate help. www.proact.org

- **SAARA**, through its adolescent affiliate U-Turn, has developed a peer mentoring model for and by young people. The peer mentoring was incorporated in, and supervised by, local treatment programs for adolescents. www.saara.org

Support Groups Based on or Deriving from 12-Step Programs

The recovery community has a long and rich history of providing peer support and mutual aid to address its own problems. Many of these have been either an offshoot or a direct extension of the 12-Step model. For example, Alcoholics Anonymous has spawned a multitude of related 12-Step groups and groups that have utilized the 12-Step model. Kurtz and Kurtz (2001) have presented a guide to

mutual aid or self-help groups that include many of the commonly known 12-Step groups including Alcoholics Anonymous www.aa.org; Narcotics Anonymous www.na.org; Cocaine Anonymous www.ca.org; Gamblers Anonymous www.gamblersanonymous.org; and Methadone Anonymous www.afirmfwc.org/methanon.htm.

They have also included groups that cater to individuals and communities that often feel excluded by 12-Step programs or that reject certain 12-Step precepts such as: Grow, Inc. ; J.A.C.S. (Jewish Alcoholics, Chemically Dependent Persons and Significant Others) www.jacsweb.org; LifeRing Secular Recovery www.unhooked.com; Moderation Management http://moderation.org; Secular Organization for Sobriety/Saving Our Selves (S.O.S.) www.cfiwest.org/sos/; Smart Recovery www.smartrecovery.org; and Women for Sobriety www.womenforsobriety.org.

There are 12-Step groups that focus on family recovery supports, such as Al-Anon Family groups www.al-anon.alateen.org, Nar-Anon Family Groups www.syix.com/mleahey/United, and Gam-Anon Family Groups www.gam-anon.org. In addition, there are a number of groups that provide peer-to-peer family and community support outside of the 12-Step paradigm. Like H.E.R.O.I.N. Hurts www.geocities.com/heartland/lake1696/, these mostly focus on offering support, resources and strategies to parents of youth who are using or are dependent on substances. Another model can be found in La Bodega de la Familia www.vera.org/bdf, a storefront on the Lower East Side of New York City that offers peer-driven walk-in services to ex-offenders in recovery and their family members. Services include support groups, computer training, health and housing referral services, job training, housing and employment information.

Recovery Clubhouses

Dating from the first AA Clubhouse established in New York City in 1942, recovery clubhouses are now a standard feature in 12-step culture in many regions. Though not officially connected to AA or any other 12-step group, these Sec. 501(c)(3) organizations own or rent their space. Governed by a Board of Directors, they are usually volunteer-run and are member supported and driven. In addition to members' dues, they also generate income by renting space to 12-step user-groups. Besides hosting 12-step meeting groups, they often offer community space to relax, play cards, socialize and drink coffee and lending libraries that provide materials with a range of recovery issues. While some recovery clubhouses sponsor such non-12-step recovery activities as open houses, educational forums, game nights, picnics and community dinners, the clubhouses maintain a predominant focus on 12-step ideology and culture.
(Example: Triangle Club, Washington, DC www.triangleclub.org).

Informal Recovery Community Affinity and Social Networks

The ingenuity and resourcefulness of people in recovery can be witnessed in the range of peer-based social and affinity group supports that communities have designed to meet their own needs. For

example, bikers in recovery (for example, Sober Bikers www.soberbikers.com), have organized "clean & sober bike runs" throughout the country that reflect their recovery in the context of their culture. Recovering individuals and families organize annual weekends that combine Big Book study with seaside recreational activities– such as "Sessions at the Sea" each September on the Maryland shore. The lesbian, gay, bisexual and transgender recovery community has organized a complex network of annual "roundups" (see Capital Roundup (www.capitalroundup.org) that take place in regions across the country. Although each one is autonomous and each format different, they often feature such things as speakers, 12-step meetings, workshops on a variety of recovery topics, talent and variety shows, and sober dances.

Recovery Management: An Emerging Construct

Relapse prevention and supports for long-term recovery are becoming wrapped in new thinking, such as recovery management. The Behavioral Health Recovery Management project www.bhrm.org, a brand-new partnership, recognizes that addiction is a chronic disease that is often addressed with a series of short-term, acute interventions. The project promotes a "consumer-centered, strengths-based service and delivery model" to address recovery as a process that needs to be self-managed over a lifetime. The website includes papers and publications by William, White, Linda and Ernie Kurtz, Mark Salzer and others.

Housing: Oxford Houses

The need of recovering people for alcohol and drug free housing in safe neighborhoods has spawned many innovative housing strategies that support recovery, and many of these approaches are owned and operated by people in recovery.

Perhaps the best known are Oxford Houses. These are self- run, self-supporting recovery residences that are patterned after 12- Step programs. The first Oxford house www.oxfordhouse.org was formed in 1975 in Silver Spring, MD in response to the closing of a halfway house. The model, since replicated in many areas, features four basic characteristics: each recovery house must: (1) utilize no paid staff; (2) operate democratically, including admission of new residents by vote of current residents; (3) expel any residents who relapse into using alcohol or drugs; and (4) be financially self-supporting. The houses offer low-cost shelter, support, fellowship and community, largely for people in recovery who are getting on their feet.

Education: Texas Tech Center for Study of Addiction

As outstanding example of a school that, under the leadership of a minister in recovery, offers both a safe haven and special programming to students in recovery is Texas Tech University in Lubbock, TX www.hs.ttu.edu/csa. Through the Center for the Study of Addiction, they have, since 1986, set the national standard for colleges and universities to help students recovering from addiction make the

transition from "recovering addict" to "responsible productive citizen" while pursuing their educational goals. Over a hundred students are in the program, many on recovery scholarships, studying, playing, working and living together. In addition to optional academic studies in addiction and addiction counseling, students are offered numerous on-campus 12-step meetings, other support groups, leadership development and peer-based tutoring and mentoring. The relapse rate has been consistently less than 5%. This school is particularly notable by its ability to attract substantial funding from the recovery community.

There are a number of high schools that have developed supports and programs for students who are in recovery, including Community High School in Nashville, TN http://communityhighschool.com/chs.htm, Sobriety High School in Edina, MN www.alternet.org/wiretapmag/story.html?StoryID=9080, and Serenity High School www.wic.org/orgs/parts.htm, San Diego, CA. Colleges and universities that have similar programs can be accessed at www.apbonline.com/safetycenter/campus/2000/02/28/recoverydorms. The Princeton Review's 2001 ranking of Stone Cold Sober Schools can be found at: http://navisite.collegeclub.com/servlet/channels.

Jobs: Social Entrepreneurial Models

There are many non-profit agencies that have adopted social entrepreneurial models, that generate income, while providing vocational skills, training and workday culture for their clients. While such models are not exactly peer-driven, they are closely linked in that they invest in the social capital of people in recovery. Author Bill Shore (1999) outlines many of these agencies in his book, **The Cathedral Within**. Another source to investigate is the Social **Entrepreneurship Toolbox** at www.np-org-dev.com. One non-profit that Shore highlights is Pioneer Human Services in Seattle, WA, www.pioneerhumanserv.com. Pioneer undertakes production in food and hotel service, manufacturing and distribution and printing, while offering job training, employment, low-cost housing and counseling to serving former criminal offenders and drug addicts.

Religion: Faith-Based Models

In addition to renting low-cost space to 12-Step and other recovery groups, some faith-based institutions offer a variety of recovery supports. Striving to meet the needs of its surrounding environs, Glide Memorial Church www.glide.org, in San Francisco, CA, integrates peer-based recovery services with meals, a walk-in center, housing services, family services, Health and HIV/AIDS services and training and employment.

MODELS OUTSIDE THE RECOVERY COMMUNITY

There are several peer-driven models that exist outside of the recovery community that offer themes and elements from which RCSP grantees can draw. Settlement Houses have a history of setting up

programs based on organizing principles of community support , community strengths and community building. The Settlement House tradition flourished in this country around the turn of the century, primarily designed to address problems faced by an immigrant population acclimating to American life. Working from a community strengths-based perspective, Settlement Houses are defined less by the services that they offer and more by their reputation as "community hubs."

Today many Settlement Houses still exist and their far-reaching influence can be seen in many community centers, Y's and neighborhood houses that emphasize a grassroots strengths-perspective of community building, community organizing and community service as a means to address community issues. Many Settlement houses still favor practice that places emphasis on group, family and community work, maintaining some distance from more clinical approaches to problem solving. A sample of Settlement/Community Houses include American Indian Community House www.aich.org, Goddard Riverside Community Center www.goddard.org, and Neighborhood House, Seattle,WA www.neighborhoodhousewa.org.

Recipients of mental health services borrowed from these models, as well as from 12-Step ideas, principles and practices, when they began to apply the notion of "recovery" to their experience and forged highly effective models of their own. The same is true for LGBT communities who were forming self-help models as one means of meeting the challenges of HIV/AIDS in the early 1980's. The reinvented models were entirely new and fresh and, in turn, set new standards. Because of this and the fact that both domains interface intimately with addiction and recovery, these are areas that RCSP grantees may want to look at closely.

Mental Health Models

Consumer/survivor peer-driven services developed, beginning in the late 1970's, as a result of "both the patient's rights movement, a civil rights movement against involuntary commitment and forced treatment, and the general self-help movement in the United States" (Sommers et al, 1999). During this time, recipients of mental health services were beginning to organize, generating energy and enthusiasm concerning their rights to define their mental illness and recovery and to be a proactive participant in their treatment plan. To some, this meant totally rejecting the existing clinical mental health field. Others took a more reformist approach, working with the mental health field as an adjunct, while pursuing a self-help and peer-based course of action.

Also during this period, in 1979, the National Alliance for the Mentally Ill (NAMI) www.nami.org was formed as a "non-profit, grassroots, self-help, support and advocacy organization of consumers, families and friends of people with severe mental illnesses "(NAMI, 2002). The early leaders of NAMI realized that to be successful, their organization needed to develop self-help and peer-driven support services in order for them to demonstrate meaningful and effective constituent organizing, develop stigma reduction activities and implement changes in delivery systems and public policy.

The past 25 years have seen a great profusion in mental health support services that are consumer-

operated and peer-driven. These supports promote empowerment, self-determination and self-efficacy. They are also a potent example of communities assessing, addressing and responding to their own needs. A peer-helping peer model also creates a relationship that offers a compassion understanding of mental illness, experience from one who has been there, and offers a social intimacy that are not possible in relationships with professional providers.

This is supported by Salzer (2002), who cites that peer support and education are effectively provided by peer mentors because of their credibility as "having been there." Salzer also outlines five types of peer-driven support that are frequently discussed in the literature: "1) Emotional Support (someone to confide in, who provides esteem, reassurance attachment and intimacy); 2) Instrumental Support (services, money, transportation); 3) Informational Support (advice/guidance, help with problem-solving and evaluation of behavior and alternative actions); 4) Companion Support (belonging, socializing, feeling connected to others); and 5) Validation (feedback, social comparison)."

Participation in peer-driven or consumer-oriented groups can help an individual access support; enhance coping mechanisms; learn from roles models, as well as become a role model to others; and build self-esteem and self-efficacy. It can also help an individual meet concrete needs of employment, housing and social supports and connections. The continuum of peer-driven supports and services is vast, ranging from simple self-help support groups to completely consumer-run drop-in centers.

International Center for Clubhouse Development
"International Standards for Clubhouse Programs"
These standards, issued for peer-driven clubhouses for mental health recipients, offer serious consideration on some pithy issues that often arise in peer-based work settings.
www.iccd.org/ClubhouseStandards.asp

"The Clubhouse Model: A Rehabilitation Approach for Mentally Ill Persons in the Community"
This short article provides some background on the clubhouse model.
www.delmarnursing.com/frisch/clubhouse.html

"How to Start and Maintain a Self-help Group"
Self Help Resource Centre, Ontario, Canada
www.selfhelp.on.ca

"Technical Assistance Guide: Consumer-run Drop-in Centers"
National Mental health Consumers' Self-Help Clearinghouse
www.selfhelp.org

Self-Help Sourcebook
Look up existing self-help groups representing a wide range of communities, interests and supports.

www.mentalhelp.net/selfhelp

National Mental Health Association of Southeastern Pennsylvania
www.mhasp.org

HIV/AIDS Models

The concept of self-help for people with HIV has been described as "taking control of our own lives, taking control in our own hands and solving our own problems through helping others in the same situation" (Elsy, 1998). By the mid-1980's, communities responded to the AIDS crisis by setting up community-based systems of support, often involving people closely affected by HIV/AIDS. These supports included newsletters, peer support groups, advocacy groups, educational and information groups, legal services and case management. Because these grassroots services were offered by the community as community needs developed, they informed the eventual infrastructure of the entire AIDS sector, demonstrated by the large number of groups "for and of" HIV positive people which continue today (Elsy, 1998).

Peer-support groups and peer-driven services have been important models in the HIV community and often project attitudes of empowerment and self-efficacy. Having a HIV diagnosis can still be a very frightening experience and having access to peer-supports can help an individual facilitate medical plans and complex medication regimens, navigate several uncoordinated and confusing systems, access case management services, provide emotional support and address stigma and discrimination. Many agencies counterbalance peer-based services with leadership development in community organizing, planning and decision making, presentation skills and advocacy. This not only provides readiness for individuals to promote systems change, but also fosters a sense of wellness through community action.

Peer-education, mentoring and peer-driven services continue to be highly effective tools in HIV prevention among youth, according to prevention researchers. Based on the credibility of peers to impact change, it has been a successful approach on both individual (changing behaviors and attitudes, building skills) and societal (establishing group norms) levels (AIDS Action 2001). In communities that are rich in social capital, grassroots peer-education has promoted successful interventions in adult populations. In communities that possess social capital, health and wellness are achieved through member participation, trust in community and community leaders, community networks and positive member identity. In this model, increasing empowerment and self-efficacy are parallel to engaging in health promoting attitudes and behaviors (Campbell and Mzaidume, 2001).

Two web resources to look at include: "What Works in HIV Prevention for Youth" www.aidsaction.org, published by AIDSAction and "Self-Help Manual: A Manual for Self-Help Groups of People Who Are Living with HIV/AIDS" www.hivselfhelp.org.uk, by The Network of Self Help HIV and AIDS Groups, London, UK.
A step-by-step "How-To" that details how to start up a self-help group for people living

Hard Text Resources

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Appendix C:
Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan Initiative

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) initiated *Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan Initiative* (NTP) to build on recent advances in the field, to bring together the best ideas about improving treatment, and to identify action recommendations that could translate ideas into practice.

The NTP combines the recommendations of five Expert Panels, with input from six public hearings and solicitation of experience and ideas through written and online comments, into a five-point strategy: (1) Invest for Results; (2) No Wrong Door to Treatment; (3) Commit to Quality; (4) Change Attitudes; and (5) Build Partnerships. The recommendations represent the collective vision of the participants in the NTP "conversation." The goal of these recommendations is to ensure that an individual needing treatment—regardless of the door or system through which he or she enters—will be identified and assessed and will receive treatment either directly or through appropriate referral. Systems must make every door the right door.

The NTP is a document for the entire substance abuse treatment field, not just CSAT. Implementing the NTP's recommendations go beyond CSAT or the Federal Government and will require commitments of energy and resources by a broad range of partners including State and local governments, providers, persons in recovery, foundations, researchers, the academic community, etc.

Copies of the NTP may be downloaded from the SAMHSA web site–www.samhsa.gov (click on CSAT and then on NTP) or from the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686.

Appendix D:
References for "Background" Section of Program Announcement

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Appendix E:
Preliminary Guidelines for Peer Recovery Support Services Manual

The manual must document at least the following information about the program:

Underlying theory and conceptual framework that directs the program

History, setting, and environmental context:
- what program does, what services are provided
- how program was developed, including information on the stakeholder analysis and findings
- organizational and community context for program
- how program interfaces with other programs and systems within the community

Participant profile, including:
- number of consumers/family members who participated in the program
- number of consumers/family members who were retained in program activities
- demographic profile of participants

Program and program structure:
- staffing and staff training
- goals
- administrative structure
- services and supports provided
- costs
- cultural, ethnic, and gender relevance and competence
- consumer enrollment process/eligibility criteria (participants, volunteers, mentors, leaders, etc.)
- legal/ethical issues (confidentiality of records and protection of participants, etc.)
- linkages with other community services and supports
- sustainability plans

Evaluation:
- GPRA measures
- local data (participant demographics and retention data) and qualitative findings ("lessons learned")

Recommendations for replication

Appendix F:
GPRA Forms

Sample Statement of Informed Consent For Follow-up Interview

At the End of the Project Activity, the RCSP Activity Leader Should Read the Following Statement to Participants:

You are being asked to assist our funder, the Center for Substance Abuse Treatment (CSAT), in assessing the activity you have just participated in. CSAT is interested in determining the impact of this program on participants' knowledge, skills, and abilities in meeting the needs of the recovery community. Your feedback will assist in identifying the most useful aspects of the session and will enable CSAT to recommend needed programmatic changes. CSAT appreciates your willingness to contribute to this assessment. By signing this consent form, you agree to complete a survey at the end of this activity and, if selected, to allow someone from [NAME OF RCSP PROJECT] to contact you via mail or by telephone for a follow-up survey.

To Activity Leader: Please read statements 1 through 3 below, and have participants read, complete, and sign the Consent and Contact Information Form <u>before</u> distributing the participant surveys. Once completed, the surveys should be kept separate from the Consent and Contact Information Forms. Completed surveys and Consent and Contact Information Forms should be placed in a sealed envelope and given to the RCSP Project Director or his/her designee. Thank you for your cooperation.

, **Procedures:**

If you agree to participate in the follow-up interview and if selected, we will need information that will allow us to contact you approximately 30 days after the completion of this event. In order for us to contact you, we ask that you complete the Consent and Contact Information form. You are also asked to provide a unique four-digit identifier (the last four digits of your Social Security number or of your birth date), which you will use on your participant survey. This way, we can match your initial response with your follow-up information.

, **Risks, Stress, Discomfort:**

There are no significant risks associated with participation in this assessment. However,

if you find answering any of the questions unpleasant or uncomfortable, you have the right to not answer any questions for any reason.

, **Protecting Participants' Rights and Confidentiality:**

You are not required to participate in this assessment and can withdraw at any time. The information you furnish us will be kept confidential. The information will not be released to anyone without your written permission. Additionally, the identifying information you give for this evaluation (last four digits of Social Security number or your birth date) will be kept separate from your name and address, and all identifying information will be destroyed after the data collection phase of the project has been completed. There is no financial compensation for participation in this assessment.

If there are no questions, ask respondents to complete and sign the Consent and Contact Information Form. Once these forms have been collected, distribute the survey.

Sample Consent and Contact Information

The purpose of this assessment has been explained to me, and I agree to participate with the understanding that there is no compensation for my participation. I also understand that, if selected, I will be asked to complete a follow-up survey about the outcomes of this activity. I agree to be contacted. I understand that the information I give will be used for evaluation purposes only and there are no significant risks involved in my participation. I understand that by providing the information requested below and signing I consent to the conditions, procedures, and release described. I understand that I do not have to participate and have the right to refuse to answer specific questions or withdraw at any time.

Participant's Signature _____

Date _____

Participant's Name (Printed) _____

Contact Information

Full Name (Print)

_____

(Last, First, Middle Initial)

Last 4 Digits of Social Security Number ***OR*** month and year of birth (e.g., 0259)

_____

Please be sure to place your personal identification code on your survey.

Home Address:

Street Address _____

_____

(City, County, State, Zip code)

Phone _____
Fax _____
E-mail address _____

Work Address (**not required** - please complete if you wish to be contacted at work for the 30-day follow up):
Organization:_____

Street Address:_____

_____

(City) (County) (State) (Zip Code)

Phone: _____Fax_____

E-mail address_____

Where do you prefer to be contacted for the follow-up? **9** Home **9** Work

Would you object to a follow-up interview by telephone? **9** No **9** Yes

Please return this form to the RCSP Activity Leader and begin responding to the survey.

Form Approved
OMB NO. 0930-0197
Exp. Date: 12/31/2004
See burden statement on the reverse side

Center for Substance Abuse Treatment

Customer Survey- RCSP Meeting/Training

Please enter the Personal ID code you used on the consent form here. _____

Date of Meeting/Training: _____

Location: _____

Title of Activity. _____

Leader/Instructor/Facilitator: _____

PLEASE INDICATE YOUR AGREEMENT WITH THESE STATEMENTS ABOUT THE MEETING/TRAINING.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I was satisfied with the content of this meeting/training.	●	●	●	●	●
2. I was satisfied with the leader/instructor/facilitator.	●	●	●	●	●
3. I was satisfied with the meeting/training materials.	●	●	●	●	●
4. Overall, I was satisfied with the meeting/training experience.	●	●	●	●	●
C The meeting/training was well organized.	●	●	●	●	●
C The leader/instructor/facilitator was knowledgeable about the subject matter.	●	●	●	●	●
7. The leader/instructor/facilitator was well prepared for the meeting/training.	●	●	●	●	●
8. The leader/instructor/facilitator was receptive to participant comments and questions.	●	●	●	●	●
9. The meeting/training was relevant to my interests and/or needs.	●	●	●	●	●
10 The meeting/training enhanced my knowledge or skills in this topic area.	●	●	●	●	●
11. I expect to use the information gained from this meeting/training .	●	●	●	●	●

PLEASE INDICATE YOUR AGREEMENT WITH THESE STATEMENTS ABOUT THE MEETING/TRAINING.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
12. I would recommend this meeting/training to others in the recovery community.	•	•	•	•	•

13. Please indicate which one title best describes your role in related to *[Insert Project Name]*:

Recovery Community Member

- Recovering person
- Family member of someone in recovery
- Non-professional supporter of recovery community
- Other, please specify:

_____

Addiction-Related Professional Supporting Recovery

- Addiction treatment provider
- Mental health provider
- Systems administrator/professional
- Government official
- Other, please specify:

_____

Other

Please specify:

_____

14. What is your gender?
- Male
- Female
- Other

15. Are you Hispanic or Latino?
- Yes
- No

16. What is your race (Mark all that apply)?

- Black or African American
- Asian American
- White American
- Alaska Native
- American Indian
- Native Hawaiian or Other Pacific Islander

17. What about the meeting/training was most useful to you?

18. How can we improve our meetings/training sessions?

Thank you for completing our survey.

Return your survey to the RCSP Activity Leader.

Form Approved
OMB NO. 0930-0197
Exp Date: 12/31/2004
See burden statement on reverse side

Center for Substance Abuse Treatment
Participant Survey-CSAT/RCSP Meeting/Training Follow-up

Personal ID code, date of training, location (i.e., city, state), and topic will be pre-coded and entered in this area of the form.

Please check here ( ) if you have received this survey in error, (i.e., you did not attend the meeting/training listed above) and return the uncompleted survey in the enclosed postage-paid envelope.

PLEASE BASE YOUR ANSWER ON HOW YOU FEEL ABOUT THE SESSION NOW.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The content of this meeting/training was satisfactory.	●	●	●	●	●
2. The leader/instructor/facilitator was satisfactory.	●	●	●	●	●
3. The meeting/training materials were satisfactory.	●	●	●	●	●
4. Overall, I was satisfied with the meeting/training experience.	●	●	●	●	●

PLEASE INDICATE YOUR AGREEMENT WITH THESE STATEMENTS ABOUT THE MEETING/TRAINING SESSION.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
C The meeting/training was relevant to my interests and/or needs.	●	●	●	●	●
C The information and/or skills presented in this meeting/training have been useful to me.	●	●	●	●	●

C The meeting/training enhanced my knowledge or skills in this topic area.	•	•	•	•	•
8. I would take additional training from [*Insert project name*].	•	•	•	•	•

9. Did you share any of the information from this meeting/training with others?	Yes •	No •
10. Did you share any of the materials from this meeting/training with others?	Yes •	No •
11. Have you applied any of what you learned in the meeting/training to your personal or family life or to your work with [*Insert project name*]?	Yes •	No •

12. What about the meeting/training was most useful to you?

13. How can [*Insert RCSP project name*] improve its meetings/training events?

Thank you for completing our survey.

Return your survey in the enclosed reply envelope.

Public reporting burden for this collection of information is estimated to average 10 minutes per response to complete this questionnaire. Send comments regarding this burden estimate or any other aspect of this collection of information to the SAMHSA Reports Clearance Officer, Room 16-105, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0197.

Appendix G:
CSAT's GPRA Strategy

OVERVIEW

The Government Performance and Results Act of 1993 (Public Law-103-62) requires all federal departments and agencies to develop strategic plans that specify what they will accomplish over a three to five year period, to annually set performance targets related to their strategic plan, and to annually report the degree to which the targets set in the previous year were met. In addition, agencies are expected to regularly conduct evaluations of their programs and to use the results of those evaluations to "explain" their success and failures based on the performance monitoring data. While the language of the statute talks about separate Annual Performance Plans and Annual Performance Reports, ASMB/HHS has chosen to incorporate the elements of the annual reports into the annual President's Budget and supporting documents. The following provides an overview of how the Center for Substance Abuse Treatment, in conjunction with the Office of the Administrator/SAMHSA, CMHS, and CSAP, are addressing these statutory requirements.

DEFINITIONS

Performance Monitoring*:* The ongoing measurement and reporting of program accomplishments, particularly progress towards preestablished goals. The monitoring can involve process, output, and outcome measures.

Evaluation: Individual systematic studies conducted periodically or "as needed" to assess how well a program is working and why particular outcomes have (or have not) been achieved.

Program: For GPRA reporting purposes, a set of activities that have a common purpose and for which targets can (will) be established.[3]

Activity: A group of grants, cooperative agreements, and contracts that together are directed toward a common objective.

Project: An individual grant, cooperative agreement, or contract.

CENTER (OR MISSION) GPRA OUTCOMES

The mission of the Center for Substance Abuse Treatment is to support and improve the effectiveness and efficiency of substance abuse treatment services throughout the United States. However, it is not

[3]GPRA gives agencies broad discretion with respect to how its statutory programs are aggregated or disaggregated for GPRA reporting purposes.

the only agency in the Federal government that has substance abuse treatment as part of its mission. The Health Care Financing Administration, Department of Veterans Affairs, and the Department of Justice all provide considerable support to substance abuse treatment. It shares with these agencies responsibility for achieving the objectives and targets for Goal 3 of the Office of National Drug Control Policy's *Performance Measures of Effectiveness*:

Reduce the Health and Social Costs Associated with Drug Use.

Objective 1 is to support and promote effective, efficient, and accessible drug treatment, ensuring the development of a system that is responsive to emerging trends in drug abuse. The individual target areas under this objective include reducing the treatment gap (Goal 3.1.1), demonstrating improved effectiveness for those completing treatment (Goal 3.1.2), reducing waiting time for treatment (Goal 3.1.3), implementing a national treatment outcome monitoring system (Goal 3.1.4), and disseminating treatment information (Goal 3.1.5). Objective 4 is to support and promote the education, training, and credentialing of professionals who work with substance abusers.

CSAT will be working closely with the OAS/SAMHSA, ONDCP, and other Federal demand reduction agencies to develop annual targets and to implement a data collection/information management strategy that will provide the necessary measures to report on an annual basis on progress toward the targets presented in the ONDCP plan. These performance measures will, at an aggregate level, provide a measure of the overall success of CSAT's activities. While it will be extremely difficult to attribute success or failure in meeting ONDCP's goals to individual programs or agencies, CSAT is committed to working with ONDCP on evaluations designed to attempt to disaggregate the effects. With regard to the data necessary to measure progress, the National Household Survey on Drug Abuse (conducted by SAMHSA) is the principal source of data on prevalence of drug abuse and on the treatment gap. Assessing progress on improving effectiveness for those completing treatment requires the implementation of a national treatment outcome monitoring system (Target 3.1.4). ONDCP is funding an effort to develop such a system and it is projected in *Performance Measures of Effectiveness* to be completed by FY 2002.

Until then, CSAT will rely on more limited data, generated within its own funded grant programs, to provide an indication of the impact that our efforts are having in these particular target areas. It will not be representative of the overall national treatment system, nor of all Federal activities that could affect these outcomes. For example, from its targeted capacity expansion program (funded at the end of FY 1998), CSAT will present baseline data on the numbers of individuals treated, percent completing treatment, percent not using illegal drugs, percent employed, and percent engaged in illegal activity (i.e., measures indicated in the ONDCP targets) in its FY 2001 report with targets for future years. As the efforts to incorporate outcome indicators into the SAPT Block Grant are completed over the next several years, these will be added to the outcomes reported from the targeted capacity expansion program.

In addition to these "end" outcomes, it is suggested that CSAT consider a routine customer service survey to provide the broadest possible range of customers (and potential customers) with a means of

providing feedback on our services and input into future efforts. We would propose an annual survey with a short, structured questionnaire that would also include an unstructured opportunity for respondents to provide additional input if they so choose.

CSATs "PROGRAMS" FOR GPRA REPORTING PURPOSES

All activities in SAMHSA (and, therefore, CSAT) have been divided into four broad areas or "programmatic goals" for GPRA reporting purposes:

- Goal 1: Assure services availability;
- Goal 2: Meet unmet and emerging needs;
- Goal 3: Bridge the gap between research and practice;
- Goal 4: and Enhance service system performance[4]

The following table provides the crosswalk between the budget/statutory authorities and the "programs":

	KD&A	TCE	SAPTBG	NDC
Goal 1			X	
Goal 2		X		
Goal 3	X			
Goal 4			X	X

KD - Knowledge Development SAPTBG - Substance Abuse Prevention and Treatment Block Grant
KA - Knowledge Application TCE - Targeted Capacity Expansion
NDC - National Data Collection/Data Infrastructure

For each GPRA [program] goal, a standard set of output and outcome measures across all SAMHSA activities is to be developed that will provide the basis for establishing targets and reporting performance. While some preliminary discussions have been held, at this time there are no agreed upon performance measures or methods for collecting and analyzing the data.[5] In the following sections,

[4]Goal 4 activities are, essentially, those activities that are funded with Block Grant set-aside dollars for which SAMHSA seeks a distinction in the budget process (i.e., National Data Collection/Data Infrastructure).

[5]Only measures of client outcomes have been developed and agreed to by each of the Centers. However, these measures are really only appropriate for "services" programs where the provision of treatment is the principal purpose of the activity (i.e., Goals 2 and 3). The client outcome measures will

CSAT's performance monitoring plans for each of the programmatic areas are presented. It should be understood that they are subject to change as the OA and other Centers enter into discussion and negotiate final measures. In addition, at the end of the document, a preliminary plan for the use of evaluation in conjunction with performance monitoring is presented for discussion purposes.

1. Assure Services Availability

Into this program goal area fall the major services activities of CSAT: the Substance Abuse Prevention and Treatment Block Grant. In FY 2000 the Block grant application was revised and approved by the Office of Management and Budget to permit the voluntary collection of data from the States. More specifically:

- Number of clients served (unduplicated)

- Increase in percentage of adults receiving services who:
  a. were currently employed or engaged in productive activities;
  b. had a permanent place to live in the community,
  c. had no/reduced involvement with the criminal justice system.

- Percent decrease in
  a. Alcohol use;
  b. Marijuana use;
  c. Cocaine use;
  d. Amphetamine use
  e. Opiate use

In addition, in the Fall of 1999 a customer satisfaction survey was designed and approved for collection from each state on the level of satisfaction with Technical Assistance and Needs Assessment Services provided to the States. More specifically:

- Increase percentage of States that express satisfaction with TA provided
- Increase percentage of TA events that result in systems, program or practice improvements

2. Meet Unmet or Emerging Needs

Into this program goal area fall the major services activities of CSAT: Targeted Capacity Expansion Grants. Simplistically, the following questions need to be answered about these activities within a performance monitoring context:

- Were identified needs met?

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be presented under Goals 2 and 3.

- Was service availability improved?
- Are client outcomes good (e.g., better than benchmarks)?

The client outcome assessment strategy mentioned earlier will provide the data necessary for CSAT to address these questions. The strategy, developed and shared by the three Centers, involves requiring each SAMHSA project that involves services to individuals to collect a uniform set of data elements from each individual at admission to services and 6 and 12 months after admission. The outcomes (as appropriate) that will be tracked using this data are:

- Percent of adults receiving services increased who:
  a. were currently employed or engaged in productive activities
  b. had a permanent place to live in the community
  c. had reduced involvement with the criminal justice system
  d. had no past month use of illegal drugs or misuse of prescription drugs
  e. experienced reduced alcohol or illegal drug related health, behavior, or social consequences, including the misuse of prescription drugs

- Percent of children/adolescents under age 18 receiving services who:
  a. were attending school
  b. were residing in a stable living environment
  c. had no involvement in the juvenile justice system
  d. had no past month use of alcohol or illegal drugs
  e. experienced reduced substance abuse related health, behavior, or social. consequences.

These data, combined with data taken from the initial grant applications, will enable CSAT to address each of the critical success questions.

3. Bridge the Gap Between Research and Practice

This "program" or goal covers that set of activities that are knowledge development/research activities. Initially funded in FY1996, CSAT's portfolio in this area currently includes multi-site grant and cooperative agreement programs, several of which are being conducted in collaboration with one or more of the other two Centers. These activities cover a broad range of substance abuse treatment issues including adult and adolescent treatment, treatments for marijuana and methamphetamine abuse, the impact of managed care on substance abuse treatment, and the persistence of treatment effects. In FY1999, a general program announcement to support knowledge development activity will be added to the CSAT portfolio.

The purpose of conducting knowledge development activities within CSAT is to provide answers to policy-relevant questions or develop cost-effective approaches to organizing or providing substance abuse treatment that can be used by the field. Simplistically then, there are two criteria of success for knowledge development activities:

- Knowledge was developed; and
- The knowledge is potentially useful to the field.

While progress toward these goals can be monitored during the conduct of the activity, only after the research data are collected, analyzed, and reported can judgments about success be made.

CSAT proposes to use a peer review process, conducted after a knowledge development activity has been completed, to generate data for GPRA reporting purposes. While the details remain to be worked out, the proposal would involve having someone (e.g., the Steering Committee in a multi-site study) prepare a document that describes the study, presents the results, and discusses their implications for substance abuse treatment. This document would be subjected to peer review (either a committee, as is done for grant application review or "field reviewers", as is done for journal articles). The reviewers would be asked to provide ratings of the activity on several scales designed to represent the quality and outcomes of the work conducted (to be developed).[6] In addition, input on other topics (such as what additional work in the area may be needed, substantive and "KD process" lessons learned, suggestions for further dissemination) would be sought. The data would be aggregated across all activities completed (i.e., reviewed) during any given fiscal year and reported in the annual GPRA report.

3.1 Promote the Adoption of Best Practices

This "program" involves promoting the adoption of best practices and is synonymous currently with Knowledge Application.[7] Within CSAT, these activities currently include the Product Development and Targeted Dissemination contract (to include TIPS, TAPS, CSAT by Fax, and Substance Abuse in Brief), the Addiction Technology Transfer Centers, and the National Leadership Institute. In FY1999, the Community Action Grant program will be added and in FY2000, the Implementing Best Practices Grant program will be added.

Activities in this program have the purpose of moving "best practices", as determined by research and other knowledge development activities, into routine use in the treatment system. Again simplistically, the immediate success of these activities can be measured by the extent to which they result in the

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[6]The ratings would include constructs such as adherence to GFA requirements, use of reliable and valid methods, extent of dissemination activities, extent of generalizability, as well as the principal GPRA outcome constructs.

[7]Most, if not all, of the activities conducted under the rubric of technical assistance and infrastructure development are appropriately classified as activities supporting this program goal. Technical assistance activities within GPRA have not been discussed within CSAT. Further, at this time, SAMHSA has a separate program goal for infrastructure development (see "Enhance Service System Performance," below).

adoption of a "best practice."[8] In order to provide appropriate GPRA measures in this area, CSAT plans to require that all activities that contribute to this goal to collect information on the numbers and types of services rendered, the receipt of the service by the clients and their satisfaction with the services, and whether the services resulted in the adoption of a best practice related to the service rendered.

4. Enhance Service System Performance

As described earlier, this programmatic goal is distinguished from "Promote the adoption of best practices" primarily by its reliance on the Block Grant set-aside for funding and the explicit emphasis on "systems" rather than more broadly on "services." The CSAT activities that fall into this goal are the STNAP and TOPPS. While CSAT has established performance measures for these activities individually, it is waiting for SAMHSA to take the lead in developing SAMHSA-wide measures. In addition, CSAT continues to believe that this goal should be collapsed into the broader goal of "Promoting the adoption of best practices."

EVALUATIONS

As defined earlier, evaluation refers to periodic efforts to validate performance monitoring data; to examine, in greater depth, the reasons why particular performance measures are changing (positively or negatively); and to address specific questions posed by program managers about their programs. These types of evaluation are explicitly described, and expected, within the GPRA framework. In fact, on an annual basis, the results of evaluations are to be presented and future evaluations described.

To date, CSAT has not developed any evaluations explicitly within the GPRA framework. The initial requirements will, of necessity, involve examinations of the reliability and validity of the performance measures developed in each of the four program areas. At the same time, it is expected that CSAT managers will begin to ask questions about the meaning of the performance monitoring data as they begin to come in and be analyzed and reported. This will provide the opportunity to design and conduct evaluations that are tied to "real" management questions and, therefore, of greater potential usefulness to CSAT. CSAT will be developing a GPRA support contract that permits CSAT to respond flexibly to these situations as they arise.

On a rotating basis, program evaluations will be conducted to validate the performance monitoring data and to extend our understanding of the impacts of the activities on the adoption of best practices.

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[8]Ultimately, the increased use of efficient and effective practices should increase the availability of services and effectiveness of the system in general. However, measures of treatment availability and effectiveness are not currently available. Within existing resources, it would not be feasible to consider developing a system of performance measurement for this purpose.

Appendix H:
Chart Summarizing RCSP II Reporting Requirements

Report	Contents	Schedule	Notes
Quarterly Progress Report	Narrative Data Chart Budget Form (format provided by CSAT)	Approximately 20 days following the end of each quarter January 20 April 20 July 20 October 20	Must submit original plus 2 copies along with diskette in Word Perfect or MS Word
GPRA Data	Compilation of results from all GPRA data collected for RCSP II training events during the quarter	Approximately 20 days following the end of each quarter January 20 April 20 July 20 October 20	CSAT will provide data base for compiling and submitting data
Work Plan	Report on the comprehensive needs assessment and planning process. (See Reporting/Evaluation Requirements section for details.)	10th to 12th month of project (end of Phase I).	Plan must be approved by Project Officer in order for grantee to proceed to Phase II. If plan not approved, project will not receive further funding.
Services Manual	Documents the service model in sufficient detail to be replicated by others.	Yearly progress reports and drafts of early sections due at the end of years 2 and 3. First full draft due 6 months before ending of project (year 4).	CSAT will synthesize information and lessons presented in manuals in technical publication for the field.